(SAMPLE MEMO TO EMPLOYEES)

M e m o r a n d u m

To: All Department Employees

FROM: Office of the Director

Subject: Resurvey of Employee Disabilities

Under the Rehabilitation Act of 1973 and California Government Code Section 19233, the State Personnel Board Requires departments to periodically provide their employees with the opportunity to self-identify their disabilities. Accordingly, I ask your cooperation in completing and returning the bottom portion of the scannable State Employee Disability Questionnaire (Std. 740). The department is firmly committed to the pursuit of equal employment opportunities for all its employees, including those with disabilities.

Please be sure to use a #2 pencil.
Do not use ink, ballpoint pen or felt tip pens.

The data that is collected from the questionnaires will only be used to prepare reports designed to identify areas where discrimination may occur and will help in the development of employment goals and actions to facilitate the employment of persons with disabilities. The information gathered will not be reviewed by a medical officer and will not identify employees individually. The data will be incorporated into the State Controller's Office of Employment History Data Base.

Note: **[Your confidentiality is guaranteed in accordance with the Privacy Act of 1974 (PL 93-579). All information on the questionnaire is requested on a voluntary basis.]** Your Social Security Number is needed to identify you as an employee of the department. If you do not provide your Social Security Number you cannot be counted as an employee with a disability.

Before completing the attached survey questionnaire, please read the instructions carefully. Answer the series of questions on the back of the scannable form. Enter your Social Security Number where indicated in the lower left front corner. Fill in the bubbles as it corresponds to your social security number. Locate the appropriate code letter for your disability, fill in the bubble in pencil, and record it in the lower portion of the form where it says "Primary Disability". If you have more that one disability, you may indicate up to three additional disabilities in the space indicated for "Secondary Disability". Please note that a code of "X" indicates no disability.

After completing the questionnaire, tear off the perforated bottom portion and return it, in a sealed envelope, to the Personnel Office by _____. The

questionnaires will then be forwarded on to the State Personnel Board. After the information has been input into the database, all questionnaires will be destroyed. If you prefer to mail you disability questionnaire directly to the State Personnel Board, you may do so.

Although completion of the disability questionnaire is voluntary, I highly encourage you to complete it accurately and return it. It is critical for the State to have complete and accurate information on the representation of employees with disabilities in order to justify programs and resources needed to facilitate the hiring of persons with disabilities. If you wish to change your status in the future, please contact the personnel office and complete another State Employee Disability Questionnaire.

If you have any questions about this survey, please contact the Personnel Office at, _____. If you have questions concerning the disability identification process, you may contact the State Personnel Board's Office of Civil Rights at (916) 653-1262 or TTY (916) 653-1498.